RELEASE OF INFORMATION

Clear Skies Psychiatry, LLC

Jody Robinson, MD

Name_____________________________________ Date of Birth ___________________

This form authorizes Dr. Robinson to release and exchange health information to/with the following providers/entities (please list name and phone/fax)

1.____
____

2.____
____

3.____
____

This information can include:
□ Copies of progress notes
□ Testing/lab results
□ Treatment plan and summary (written and verbal)
□ All of the Above
□ Other (Specify):

This authorization shall remain in effect until the end of treatment unless another end date is specified:
Date:_______________________ Initials: _______

I understand that I may revoke this consent at any time by notifying this office in writing. Such revocation will not extend to release of information that has already occurred from this authorization.

____ _______________________
Signature of patient or guardian Date

____
Printed name of patient (or representative and relationship to patient)